WHITE HOUSE CONFERENCE ON AGING
POST-EVENT SUMMARY REPORT

WHITE HOUSE CONFERENCE ON AGING AGENDA AREA: ACCESS TO AFFORDABLE, QUALITY HEALTH CARE

Name of Event: Seminar entitled "Access to Affordable, Quality Health Care: A Contradiction in Terms?"

Date of the Event: 04/07/2005

Location of the Event: The Chicago Bar Association, 321 South Plymouth Court, Chicago, Illinois

Number of Persons Attending: 55

Sponsoring Organizations: The Task Force on Issues Affecting Women as They Age of The Chicago Bar Association and Women's Bar Association of Illinois

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EVENT SUMMARY:

Fifty-five persons including professionals, students, retirees, advocates and educators attended this fourth session of an educational series sponsored by the Task Force. This session featured presentations by Brent Adams, Policy Director for Citizen Action/Illinois; Kelly Kleiman, freelance journalist/author; and Usha Ranji, Senior Policy Analyst for Women's Health Policy, Kaiser Family Foundation. Jean Galovich of HealthMax, Inc. served as moderator. After the general session, the Task Force members convened to review the material presented, discuss it with several of the panelists and formulate a priority area and solutions for the 2005 White House Conference on Aging.

PROBLEM STATEMENT

Quality Health Care is not universally available and affordable, especially for women as they age. The current bias toward employer sponsored plans and Federal/State plans for the indigent leaves 20% of all Americans uncovered or under-insured. Among the individuals excluded are the self-employed, the part-time worker, the unemployed and the partially or temporarily disabled. Many of

these are low-income women, displaced homemakers, and spouses who are excluded from programs that do not extend to them by virtue of age or other exclusions. This lack of insurance creates or exacerbates other problems such as diminished quality of life, premature death, unpaid medical bills, and personal bankruptcies, and increases the overall cost of insurance and health care. The lack of coverage for one person can affect whole families and entire self-insured groups (e.g., religious communities, Native American Tribes). It has been proven that people with health insurance get better medical care, including preventive care, and have better health outcomes than the uninsured and under-insured. Healthy people are essential for a healthy, strong nation and the overall productivity of America.

PRIORITY ISSUE

Health Insurance for those currently without coverage must be made affordable through National Health Insurance or public/private collaborations sponsored by State Agencies.

Barriers:

- The current health insurance system is not a system at all (an interdependent group forming a unified whole) and this is the root of the problem. Currently, health insurance coverage is based mainly on group-rated markets: if one is not covered under a specified group, access to pre-paid health plans (inaccurately called "insurance") for health care is limited to catastrophic expenses, is expensive and is often unavailable.
- Medical professionals are often prohibited by risk of financial penalties or exclusion by covered plans from negotiating rates with the uninsured or under-insured.
- Medical professionals often have no concept of the cost of treatments, referrals to specialists or drugs that they recommend, given the labyrinthine methods for their own remuneration through these health care groups.
- The current Administration lauds the "ownership society" and the entrepreneur while ignoring the needs of a significant population for portable benefits.
- This problem is increasing as the population ages and becomes sicker and more individuals become uninsurable. It is not a problem that will resolve itself without action. The costs involved are growing: currently 20% of all insurance payments fund for administration of the plan and the process of "screening" out ineligible payments and individuals.

- Employer provided health insurance plans are based on an archaic model of long term employment and retirement benefits that continue health insurance. This model was based on a post W.W.II economy, whereas the reality today is movement among many employers over a working lifespan, self-employment, part time employment and moving in and out of the work force, particularly for single mothers, widows and elderly women. Meanwhile, many employers are discontinuing retirement health benefit plans (often abruptly) and shifting the cost of coverage to employees. (Example: as of 2005 all new hires to Chicago City Government positions will NOT carry forward any health benefits into their retirement.) Meanwhile, the current health insurance model assumes that employers bear most of the costs and most individuals are covered through employer plans.

Solutions:

- Solutions are available and we have models. The most recognizable models are the Federal Social Security System for disability/retirement benefits and the Medicare system for coverage for disabled individuals and those over 65. These mandatory programs cover 92% of the population. With these as models, the most obvious solution is a single payer National Health Care Program.
- We have another voluntary model in the way Congress addressed the growing realization that individuals no longer are employed by one or two entities during their working years. IRAs of several different types were authorized in the 1980's as were employee deferred compensation savings plans (401k, 403b, Thrift Savings Plan). Many of these plans contain employer contribution features and all are portable, some are tax free upon eligibility to withdraw. Extensive public education on the benefits of such savings plans has resulted in trillions of dollars reserved for retirement benefits for participating individuals. The first counsel of all financial planners is to 1) buy a home and 2) contribute to your 401k/employer deferred compensation plan or IRA to the maximum extent that you can. Some positive steps have been made by Congress in the health insurance arena by permitting pre-tax dollars to be reserved for medical expenses in Medical or Health Care Savings Accounts. But not all persons can contribute to such plans, especially low-income older women who are often part-time workers, domestic help, self-employed or do not have employers that sponsor such plans. We need large risk-pooled health benefit plans to cover the 20% those Americans who are left behind.
- Public-Private Partnerships can fill the gaps for uncovered groups. The Task Force suggests that the WHCoA review the proposed Healthy Illinois Act (Illinois Senate Bill 11, www.ILGA.gov), a model developed by the Illinois for Health Care Campaign of the Citizen Action/Illinois non-profit advocacy group. The elements of this plan are:

-- Healthy Illinois would form a pool of small businesses, self-employed people, and individuals who do not have access to employer-based health coverage. Through the pool, Healthy Illinois can gain the leverage of massive group bargaining to negotiate affordable premiums for everyone in the group, thus uniting the uninsured and underinsured in a single group.
-- A public-private partnership is formed under which the State, following public bidding, would contract with a private insurer to provide the health insurance.
-- This voluntary insurance program would provide premium discounts based on household income up to 300 percent of the federal poverty level. At that current rate, for example, individuals with annual income (not assets) of $28,000 or less and families of five with earnings of $65,000 or less, would qualify for a sliding scale discount.
-- The goals of the program are access, cost reduction and quality of care which are built into this model.

CONCLUSION:

The United States of America is proud of its capitalistic economic base: a system marked by open competition in a free market that celebrates the entrepreneur who assumes the risks of potential reward. Since the Great Depression, however, we have recognized that not all individuals can compete equally or successfully in this system, given the vagaries and inequities of life, the markets, catastrophic events to both individuals and corporations, and the individual capabilities and opportunities of its citizenry. Social programs were enacted to form a "safety net" for those left outside of this system, and these measures have resulted in the strongest nation in the world. A healthy nation is a strong nation. A long-lived population contributes to the strength of families and future generations and a strong economic system. We have the best health care providers in the world and without question the finest medical facilities, and we must not deny our own citizens access to them. We can make quality health care accessible and affordable to our citizenry by using models of private/public partnerships like those described in the Report.

Sponsoring Organizations: The Chicago Bar Association and The Women's Bar Association of Illinois

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